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Citation for published version:

Andreangeli, A, Access to All Areas? Maybe Not...The Future of Scotland's NHS and the EU/US Transatlantic Trade and Investment Partnership Agreement, 2014, Web publication/site, Scottish Constitutional Futures Forum.

Link:

[Link to publication record in Edinburgh Research Explorer](#)

Document Version:

Publisher's PDF, also known as Version of record

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Arianna Andreangelli: Access to All Areas? Maybe Not ... The Future of Scotland's NHS and the EU/US Transatlantic Trade and Investment Partnership Agreement

Posted on August 27 2014

The negotiations between the European Union and the United States with a view to drafting and concluding the Transatlantic Trade and Investment Partnership Agreement (TTIP) have been met with very mixed reaction across civil society, the legal community and domestic policymakers on either side of the Atlantic. A little more than a year ago the EU Commission headed by Mr Barroso hailed these negotiations as a prime opportunity for "delivering better access to the US market" for European firms and thereby "unleashing untapped potential of a truly transatlantic market place".^[1] In the Economic Study commissioned by the Commission it was illustrated how the implementation of the new agreement would have yielded increases of EU exports to the US of about 28% and, overall, a rise in cross-Atlantic trade of 6% for the EU and 8% for the US.^[2]

Not all other stakeholders, however, were as enthusiastic: civil society groups, for instance, expressed grave concerns at the perceived lack of transparency surrounding the negotiations.^[3] Alongside concerns of a procedural nature were deeper-seated fears relating to the substantive content of the agreement: several non-governmental bodies and civil society groups argued that adhering to such a wide ranging agreement, by seeking to attain greater regulatory coherence, would have led to the lowering of technical, environmental, employment and social standards in Europe.^[4] It was also feared that the stipulation of the TTIP would have de facto significantly limited the powers of the Member States' Governments to regulate specific sectors of the economy, especially in light of its provisions seeking to establish a framework for investor-state disputes.^[5]

This admittedly bleak depiction of the impact of the TTIP was to an extent counterbalanced by governmental voices: the British Government, among others, argued that the TTIP would have made the relationship with the US stronger and thereby added "as much as £10 million annually to the UK economy in the long term" not only via the elimination of almost all the existing tariff barriers but also through ensuring "reduced bureaucracy and greater regulatory coherence".^[6] Also, it was forcefully argued that the TTIP, rather than leading to a "race to the bottom" in a number of areas, including that of technical standards and of safeguards enjoyed by workers and by consumers would have led to greater regulatory coherence between the two jurisdictions, by allowing the parties to "take stock" of the normative and regulatory status quo and eliminate duplications.^[7] The Government sought to address one of the concerns raised by the 14th report of the House of Lords' EU Select Committee report on the TTIP, namely the need to "disentangle" those concerns stemming from the negotiations that were not as "well-founded" as others (such as, inter alia, those stemming from the lack of transparency arising from the negotiations or those relating to future impacts of the TTIP's tariff abolitions on developing countries)^[8]. Its Response emphasised that adhering to the TTIP's investment protection and investor-state dispute settlement mechanisms would not have prejudiced the right of individual states to regulate specific sectors of the economy: provided that they were framed in a way that allows a "fair balance" to be struck between the state's right to formulate policies in the public interest and ensuring effective protection to the legitimate rights of investors,^[9] these provisions were seen as a realistic opportunity to provide a transparent and effective "enforcement mechanism"^[10] for foreign investors' rights while seeking to avoid spurious claims that could overtime hamper the states' regulatory prerogatives.^[11]

Protecting public services and especially the provision of "highest quality health care at the point of need" was an extremely pressing concern for civil society, especially in the UK. Many argued that the TTIP would have given American and, more generally, multi-national companies the right to enter and operate without obstacles within the European and, more specifically, the British market;^[12] it was also claimed that these companies could have relied on their expectation of equal treatment to access subsidies and, in the event of new regulations being introduced, could have availed of the investor-state dispute settlement framework to obtain compensation for the loss of future profits caused by the new rules.^[13] More generally, it was feared that, as a result of the partnership agreement, a "wholesale privatisation" of the NHS would have been set in motion.^[14]

It is well-known that significant changes have been taken place in the NHS since the Coalition Government took up office in Westminster: the Health and Social Care Act 2012 has had a wide-ranging impact on the way in which healthcare services are organised and provided to patients: the Act has heralded the almost wholesale application of the competition rules to health and social care provision, with clinical commissioning groups being responsible for the purchase of services from "providers", namely NHS trusts.^[15] It is therefore suggested that the 2012 reforms reflect closely a "neoliberal model" for the provision of health care services which ushers greater involvement on the part of private providers whose objectives may not necessarily be of a "mutualistic" and "solidarity based" nature.^[16]

Scotland, as is well-known, has taken a rather different route: the Scottish Parliament, to which health and social care have been devolved, has expressly maintained the NHS "in public hands", via the rejection of the NHS trusts as providers of services and through replacing an "internal market" of services with a culture of cooperation.^[17] Today, its running is devolved by the Government to a structure of fourteen area boards, responsible for the allocation of resources and the implementation of healthcare strategies via Community Health Partnerships and Operating Divisions.^[18]

Against this background, should we fear for the continued integrity of a public NHS for Scotland, Scotland either becomes a member of the EU in the event of a vote for independence or remains within the UK in case of a 'No vote' and the TTIP is concluded? Is there anything either in the existing EU acquis or in the obligations enshrined in the agreement itself that can eventually "force" a marketization of health services north of the Border?

The Court of Justice of the EU has consistently held that member States are "sovereign" over their health services: in, inter alia, Watts the Court took the view that EU law would not hamper the power of the Member States to autonomously design and regulate their health care services.^[19] According to Article 168 of the TFEU the attainment of a "high level of human health protection shall be ensured" as part of all EU policies: the provision goes on to specify, however, that this remains an area of competence shared with the Member States, with the Union only empowered to adopt "supporting" measures, especially so as to foster coordination among domestic policies.^[20] At the heart of Article 168 is a clear commitment to the principle of subsidiarity, as a result of which the EU undertakes to respect as well as to support the national authorities in the adoption of key decisions in the area of healthcare provision.^[21] As a result, each Member State can choose how to design

and regulate health care systems: in the spectrum of choices available to it, it can opt for maintain the provision of its services firmly entrenched within its own structure, thus limiting private sector involvement to the minimum, if it regards this as “appropriate” for the needs of its population and so long as the general principles underscoring the Treaty, most importantly the rules on free movement of persons and of services, are respected.^[22] Member States can, inter alia, restrict the freedom of movement of persons, including their nationals, for the purpose of seeking and receiving medical treatment in another Member State in certain circumstances if that restriction aims to prevent the financial stability of the system from being undermined, thus threatening treatment capacity level and, ultimately the survival of the population.^[23]

In addition, it should be borne in mind that whenever health authorities and boards are engaged in purchase or supply activities in the context of their institutional mandate as providers of “social goods” such as healthcare services “free at the point of need” and without a “profit motive”, they do not act as “undertakings” for the purpose of competition law and, consequently, even though they may yield, for instance, significant purchasing power are not subject to the application of free market principles.^[24]

Against this background, it is argued that it seems unlikely for the TTIP to change the status quo: it is submitted that any international law commitments to greater openness of the single market vis-à-vis US providers, undertaken by the Union, could not impact on the Member States’ power to design and regulate their healthcare systems since this is an area in which the Founding Treaties confer to the EU only “supporting and coordinating” competence.^[25] Unless the Member States were willing to “sacrifice their autonomy” vis-à-vis the regulation of mechanisms for the provision of “essential services to the person” in favour of Union powers in the area, through treaty amendment—e.g. by moving from the current system of “shared” and “supporting competence” to a more integrated approach in which the EU becomes responsible for aspects of health care provision going beyond, inter alia, the free movement of medical services^[26]—Union measures, either internal or external, would not be capable of encroaching upon the Member States’ powers to regulate these public services.

It must be emphasised that the awareness of the limited reach of the Union competences vis-à-vis the provision of health care is reflected in the EU Commission’s mandate for the negotiation of the TTIP itself:^[27] a memorandum published in July 2014 by DG Trade^[28] confirms that the partnership deal would preserve the power of EU Governments to limit the reach of the principle of “national treatment” and “market access” to healthcare provision, including the possibility of opening up health care markets to competition^[29] and of reducing the scope for third country individuals and firms to enter and operate within the single market.^[30]

Finally, it should be highlighted that the recent agreement reached by the EU and Canada on a “Comprehensive Economic and Trade Agreement”^[31] confirms the commitment to preserving the Member States’ power to regulate the manner of public services provision, including health care, thus remaining consistent with the need to preserve their powers to regulate the health care sector, by limiting the reach of the principle of equal treatment for non-EU providers.^[32]

Arguably, similar conclusions may be reached when it comes to assessing the extent to which the proposed TTIP’s objective of opening up public procurement markets to external providers: according to the EU Commission’s Mandate, obtaining greater access to US public procurement, at least at Federal level, represented a key objective of the Union’s negotiating position^[33] together with a corresponding commitment to “increasing transparency” in respect of the member states’ procurement activities and thereby allowing US businesses to bid for these contracts, in conditions of non-discrimination.^[34]

Admittedly this is an area which, as was recognised by the EU Select Committee of the Lords, is likely to be hard-fought.^[35] Nonetheless, it is argued that individual member states would likely be able to limit access to non-EU companies to bidding procedures for the award of healthcare services contracts. First of all, according to the *Teckal* judgment, the requirements introduced by the EU rules on public procurement would not apply to contracts granted to another body under the control of the contracting authority or for services that are going to be supplied “in-house”.^[36] The *Commission v Ireland* decision also stated that contracting authorities would not be obliged to “go out to tender” if services were entrusted with another public body and performed as part of their statutory duties.^[37]

Secondly, it should be emphasised that the award of contracts for the provision of “essential services to the person”, including healthcare, has traditionally been subject to a “light touch regime”^[38] since due to their nature, they are not always likely to be of “interest” to foreign providers.^[39] More generally, the EU measures harmonising the award of public contracts reflect the same principle enshrined in Article 168 TFEU, namely that national authorities retain discretion as to how to organise the delivery of these services, including the possibility of either provide them in-house or to “in a way that does not entail the conclusion of public service contracts”.^[40] Thus, these contracts are still subject to requirements of transparency as any other public service contract;^[41] however, awarding authorities will be allowed to apply award criteria that seek to uphold “non-market principles” such as, inter alia, continuity and accessibility of services^[42] and in that context will be able to, for instance, limit participation to the tendering process to cooperative organisations or other bodies based on employee or end-user involvement.^[43]

Having regard to access to these procedures on the part of third country nationals, it is clear from the current tone of the negotiations that principles of non-discrimination should govern this issue under the TTIP; however, as both the WTO’s General Procurement Agreement (GPA) and the recent EU-Canada Trade agreement seem to suggest, there is every reason to believe that “essential services to the person” will be broadly excluded from any future deal with the US. According to Annex IV to the WTO GPA,^[44] “social and health services” are expressly excluded from the principle of equal treatment, thus allowing signatory states to restrict access to the market for the provision of these services to foreign suppliers; in addition, as illustrated above, CETA expressly exclude these services from the scope of the agreement.^[45]

It may therefore be concluded that, whether in the event of a ‘No vote’, or, if the ‘Yes’ prevails and EU membership is successfully sought, the future conclusion of the TTIP will not threaten Scotland’s power to design, regulate and finance health care services via its NHS in the way it sees “appropriate to the needs of its population”. Article 168 TFEU is in fact going to preserve its “sovereignty” over health services without allowing the Union, by virtue of the limited nature of its competence to instigate the “marketization of health services” that the TTIP detractors fear may follow from the agreement’s stipulation.^[46] In addition, the “light touch” regime envisaged by EU public procurement legislation concerning the award of public contracts for the supply of “essential services to the person” provides scope for contracting authorities to, inter alia, apply certain “non-market” based criteria for the selection of winning bidders and to restrict the participation of non-EU firms on the ground that “opening up” the pool of bidders would not be consistent with principles of accessibility and continuity of service.

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^[1] “Member States endorse EU-US trade negotiations”, 14 June 2013.

^[2] “Independent study outlines benefits of EU-US agreement”, 12 March 2013.

^[3] See e.g. “Civil Society call for full transparency in EU-US trade negotiations”, from Corporate Europe Observatory, 19 May 2014; also, among others, see the [letter](#) signed by Friends of the Earth Europe on behalf of other 250 organisations

^[4] Ibid.

^[5] “Commission ISDS reform plans is an echo chamber of business views”, 3 July 2014.

^[6] [Response to the House of Lords EU Committee’s 14th Report](#), July 2014, p. 5.

^[7] Response, cit. (fn. 6), p. 10.

- [8] House of Lords Select Committee on the EU, Sub-committee C, 14th Report, [“The Transatlantic Trade and investment partnership agreement”](#), session 2013-14, para. 78-79.
- [9] Response, cit. (fn. 6), pp. 24-26.
- [10] 14th Report, cit. (fn. 8), para 167.
- [11] Response, cit. (fn. 6), p. 25-26.
- [12] See: <http://www.patients4nhs.org.uk/eu-us-free-trade-agreement-or-ttip/>.
- [13] Ibid.
- [14] John HJilary, [“On TTIP and the NHS, they’re trying to bamboozle us”](#), 14 July 2014. Cf. Response, cit. (fn. 6), p. 11.
- [15] See inter alia Curran and Albert, “It seemed a good idea at the time”, (2014) 35(9) ECLR 419; see also Pownall, “Neoliberalism, austerity and the Health and Social Care Act 2012”, (2013) 42(4) Industrial L J 422 at 429-430.
- [16] See e.g. Pownall, “Neoliberalism, austerity and the Health and Social Care Act 2012”, (2013) 42(4) Industrial L J 422 at 429-430.
- [17] See e.g. SPICe Briefing, “The National Health Service in Scotland”, 21 June 2011, No 11/49, pp. 5-6.
- [18] Ibid.
- [19] Case C372/04, Watts, [2006] ECR I-4325, para. 86.
- [20] See e.g. , mutatis mutandis, case C158/96, Kohll, [1998] ECR I-1931, para. 18.
- [21] See inter alia, Needergard, “EU Health care law in a constitutional light”, in van den Gronden et al., “Health Care and EU law”, 2011 Asser Press, p. 19, see especially pp.24-25.
- [22] See inter alia case C157/99, Geraets-Smits et al., [2001] ECR I-5473, para. 44-45.
- [23] See Watts, cit. (fn. 19), para. 86-87.
- [24] See chiefly case T-319/99, Fenin v Commission, [2003] ECR II-357, para. 36-39.
- [25] See inter alia Szyszczak, “Patients’ Rights: a lost cause or a missed opportunity?”, in van den Gronden et al, cit. (fn. 21), 103 at 119-120.
- [26] Directive 2011/24/EU of 9 March 2011 on the application of patients’ rights to cross-border healthcare, OJ 2011 L88/45; see especially Preamble, Recitals 3,4 and 8; cf. Recital 7.
- [27] See: <http://trade.ec.europa.eu/doclib/press/index.cfm?id=918>. A text of the draft mandate was leaked in March 2013 to the “Inside US Trade” website; it was marked with the reference: COM(2013) 136 final; see also, mutatis mutandis, [Article 14, General Agreement on Trade in Services](#); see also draft mandate, cit. (fn. 39), Annex, para. 6 and 14.
- [28] See: <http://trade.ec.europa.eu/doclib/press/index.cfm?id=1115>.
- [29] Ibid.
- [30] Ibid.
- [31] See: <http://trade.ec.europa.eu/doclib/press/index.cfm?id=973>.
- [32] See Government of Canada, [“Opening new markets in Europe—an Overview of the Canada-EU Comprehensive Economic Trade agreement”](#), (2013), p. 24.
- [33] See e.g. [State of Play of negotiations after 6th Round](#), July 2014, p. 2.
- [34] See inter alia, [Communications of 14 June 2013](#).
- [35] See 14th Report, cit. (fn. 8), para. 137-138.
- [36] Case C-107/98, Teckal Srl, [1999] ECR I-8121, para. 49-51. See also, mutatis mutandis, case C-300/07, H & C Oymanns GbR and others, [2009] ECR I-4779, para. 71-76.
- [37] Case C-532/03, Commission v Ireland, [2007] ECR I-801, para. 26-28; see also para. 35-36.
- [38] See also Directive 2004/18/EC, OJ 2004 L134/114, Annex II B.
- [39] Inter alia, see case C-321/03, Coname, ECR I-7287, para. 16-19.
- [40] Directive 2014/24/EU, 2014 OJ L94/65, see especially recital 114.
- [41] See e.g. case C-324/98, Telaustria, [2000] ECR I10745, para. 60-61.
- [42] Directive 2014/24/EU, cit. (fn. 40), Recital 118.
- [43] Ibid.; see also, inter alia, [NHS European Office Briefing](#), September 2013, Issue 14, p. 4.
- [44] WTO, [General Procurement Agreement, Appendices and Annexes](#).
- [45] See e.g. “Opening new markets in Europe”, cit. (fn. 32), p. 24-25.
- [46] See also, mutatis mutandis, Directive 2011/24/EC, cit., (fn. 26), Preamble, Recital 12.

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